FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037762

Facility Name: ALBANY CARE, INC.

Address: 901 MAPLE (Number) EVANSTON (City) 60202 (Zip Code)

County: COOK

Telephone Number: (847) 475-4000 **Fax #** (847) 475-8316

IDPA ID Number: 36-3764987-001

Date of Initial License for Current Owners: 11/01/91

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) CARY C. BUXBAUM, C.P.A.
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	417	Intermediate (ICF)	417	152,622	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	417	TOTALS	417	152,622	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0				8
9	SNF/PED					9
10	ICF	136,854	1,451	46	138,351	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	136,854	1,451	46	138,351	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.65%

D. How many bed-hold days during this year were paid by Public Aid?
4,601 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
n/a

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/01/91

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	236,108	48,206	64,140	348,454		348,454	(41,268)	307,186			1
2	Food Purchase		409,569		409,569	(13,908)	395,661	(43)	395,618			2
3	Housekeeping	209,968	39,066		249,034		249,034	1,009	250,043			3
4	Laundry		21,422	21,205	42,627		42,627		42,627			4
5	Heat and Other Utilities			218,515	218,515		218,515	4,269	222,784			5
6	Maintenance	53,518	19,721	221,347	294,586		294,586	(76,787)	217,799			6
7	Other (specify):*							12,718	12,718			7
8	**TOTAL General Services**	499,594	537,984	525,207	1,562,785	(13,908)	1,548,877	(100,102)	1,448,775			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,822,560	26,221	275,159	2,123,940		2,123,940	(44,224)	2,079,716			10
10a	Therapy			41,657	41,657		41,657	(11,906)	29,751			10a
11	Activities	402,520	16,546		419,066		419,066		419,066			11
12	Social Services	409,412			409,412		409,412		409,412			12
13	Nurse Aide Training											13
14	Program Transportation			4,023	4,023		4,023		4,023			14
15	Other (specify):*							10,803	10,803			15
16	**TOTAL Health Care and Programs**	2,634,492	42,767	323,839	3,001,098		3,001,098	(45,327)	2,955,771			16
	C. General Administration											
17	Administrative	176,870		946,448	1,123,318		1,123,318	(710,463)	412,855			17
18	Directors Fees											18
19	Professional Services			263,681	263,681		263,681	(147,214)	116,467			19
20	Dues, Fees, Subscriptions & Promotions			58,011	58,011		58,011	(2,225)	55,786			20
21	Clerical & General Office Expenses	260,420	89,949	131,734	482,103		482,103	(36,156)	445,947			21
22	Employee Benefits & Payroll Taxes			488,798	488,798	13,908	502,706	(6,600)	496,106			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,341	4,341		4,341	(1,216)	3,125			24
25	Other Admin. Staff Transportation			7,724	7,724		7,724	413	8,137			25
26	Insurance-Prop.Liab.Malpractice			118,494	118,494		118,494	1,945	120,439			26
27	Other (specify):*							47,840	47,840			27
28	**TOTAL General Administration**	437,290	89,949	2,019,231	2,546,470	13,908	2,560,378	(853,676)	1,706,702			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,571,376	670,700	2,868,277	7,110,353		7,110,353	(999,105)	6,111,248			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

ALBANY CARE, INC.
0037762
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	13,908	
2	FOOD		13,908

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

Facility Name & ID Number ALBANY CARE, INC. #0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			73,311	73,311		73,311	247,877	321,188			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			14,213	14,213		14,213	1,053,721	1,067,934			32
33	Real Estate Taxes			462,696	462,696		462,696	8,764	471,460			33
34	Rent-Facility & Grounds			1,738,491	1,738,491		1,738,491	(1,738,491)				34
35	Rent-Equipment & Vehicles			31,928	31,928		31,928	6,097	38,025			35
36	Other (specify):*							19,855	19,855			36
37	**TOTAL Ownership**			2,320,639	2,320,639		2,320,639	(402,177)	1,918,462			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,934	228,934		228,934		228,934			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			228,934	228,934		228,934		228,934			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,571,376	670,700	5,417,850	9,659,926		9,659,926	(1,401,282)	8,258,644			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,313)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(43)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,889)	21		24
25	Fund Raising, Advertising and Promotional	(3,038)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(41,402)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(150,219)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (215,404)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,185,878)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,185,878)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,401,282)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ALBANY CARE, INC.

ID# 0037762

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$ 1,926	6	1
2	Capitalized Repairs & Maintenance	(32,107)	6	2
3	Collection Fees	(250)	19	3
4	Political contributions - COPE (IL Council)	(543)	20	4
5	Out of State Seminars	(320)	24	5
6	Veteran's prescription Drugs	(311)	10	6
7	Jury Duty - CNA's	(190)	10	7
8	Interest Income	(22,836)	32	8
9	Income from Rental of facility space	(5,463)	35	9
10	Director's Fees	(90,125)	17	10
11				11
12				12
13				13
14				14
15				15
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87				87
88				88
89				89
90	Total	(150,219)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number ALBANY CARE, INC. # 0037762 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(41,268)							(41,268)	1
2	Food Purchase	(43)											(43)	2
3	Housekeeping			1,009									1,009	3
4	Laundry													4
5	Heat and Other Utilities			1,362	2,907								4,269	5
6	Maintenance	(30,181)		840	(23,840)	(23,606)							(76,787)	6
7	Other (specify):*				1,560	11,158							12,718	7
8	**TOTAL General Services**	(30,224)		3,211	(19,373)	(53,716)							(100,102)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(501)			(43,723)								(44,224)	10
10a	Therapy					(11,906)							(11,906)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				6,575	4,228							10,803	15
16	**TOTAL Health Care and Programs**	(501)			(37,148)	(7,678)							(45,327)	16
	C. General Administration													
17	Administrative	(90,125)		23,562	(37,055)	(609,228)		2,383					(710,463)	17
18	Directors Fees													18
19	Professional Services	(250)		(142,466)	(29,013)	24,450		65					(147,214)	19
20	Fees, Subscriptions & Promotions	(5,081)		606	2,207			43					(2,225)	20
21	Clerical & General Office Expenses	(58,291)		78,239	9,994	(66,192)		94					(36,156)	21
22	Employee Benefits & Payroll Taxes					(6,600)							(6,600)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(320)		308	1,196	(2,400)							(1,216)	24
25	Other Admin. Staff Transportation			1,072	5,341	(6,000)							413	25
26	Insurance-Prop.Liab.Malpractice			687	1,177			81					1,945	26
27	Other (specify):*			12,292	9,851	24,652		1,045					47,840	27
28	**TOTAL General Administration**	(154,067)		(25,700)	(36,302)	(641,318)		3,711					(853,676)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(184,792)		(22,489)	(92,823)	(702,712)		3,711					(999,105)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ALBANY CARE, INC. # 0037762 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	(2,313)	234,183	5,022	10,985								247,877	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(22,836)	1,068,030	1,960	6,506			61					1,053,721	32
33	Real Estate Taxes			2,535	6,229								8,764	33
34	Rent-Facility & Grounds		(1,738,491)										(1,738,491)	34
35	Rent-Equipment & Vehicles	(5,463)		4,334	13,300	(7,200)		1,126					6,097	35
36	Other (specify):*		19,855										19,855	36
37	**TOTAL Ownership**	(30,612)	(416,423)	13,851	37,020	(7,200)		1,187					(402,177)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(215,404)	(416,423)	(8,638)	(55,803)	(709,912)		4,898					(1,401,282)	45

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Scheduled Attached		See Scheduled Attached		See Scheduled Attached		
				Albany Care LLC	Lincolnwood, IL	building ptnshp

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 1,738,491	Albany Care LLC	100.00%	$	$ (1,738,491)	1
2	V	32	Interest Income	324	Albany Care LLC	100.00%		(324)	2
3	V	32	Interest Expense		Albany Care LLC	100.00%	1,068,354	1,068,354	3
4	V	30	Depreciation		Albany Care LLC	100.00%	234,183	234,183	4
5	V	36	Amortization		Albany Care LLC	100.00%	19,855	19,855	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,738,815			$ 1,322,392	$ * (416,423)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 1,009	$ 1,009	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,362	1,362	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	840	840	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	23,562	23,562	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	3,134	3,134	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	606	606	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	78,239	78,239	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	308	308	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	1,072	1,072	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	687	687	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	12,292	12,292	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	5,022	5,022	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	1,960	1,960	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	2,535	2,535	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	4,334	4,334	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	145,600	PREFERRED BOOKKEEPING	100.00%		(145,600)	32
33	V	19	COMPUTER	10,008	PREFERRED BOOKKEEPING	100.00%	10,008		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 155,608			$ 146,970	$ * (8,638)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 2,907	$ 2,907	15
16	V	6	REPAIRS AND MAINT.	37,536	S.I.R. MANAGEMENT, INC.	100.00%	13,696	(23,840)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	1,560	1,560	17
18	V	10	NURSING	82,572	S.I.R. MANAGEMENT, INC.	100.00%	38,849	(43,723)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	6,575	6,575	19
20	V	17	ADMINISTRATIVE	52,548	S.I.R. MANAGEMENT, INC.	100.00%	15,493	(37,055)	20
21	V	19	PROFESSIONAL FEES	33,780	S.I.R. MANAGEMENT, INC.	100.00%	4,767	(29,013)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	2,207	2,207	22
23	V	21	CLERICAL & GENERAL	42,540	S.I.R. MANAGEMENT, INC.	100.00%	52,534	9,994	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	1,196	1,196	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	5,341	5,341	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,177	1,177	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	9,851	9,851	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	10,985	10,985	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	6,506	6,506	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	6,229	6,229	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	13,300	13,300	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 248,976			$ 193,173	$ * (55,803)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 42,540	S.I.R. MANAGEMENT, INC.	100.00%	$ 11,216	$ (31,324)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	1,887	1,887	16
17	V	17	ADMIN./LEGAL SALARIES	788,175	S.I.R. MANAGEMENT, INC.	100.00%	178,947	(609,228)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	24,450	24,450	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	24,652	24,652	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	37,032	S.I.R. MANAGEMENT, INC.	100.00%	25,126	(11,906)	22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	4,228	4,228	23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	59,884	S.I.R. MANAGEMENT, INC.	100.00%	41,678	(18,206)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	7,256	7,256	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	21,600	S.I.R. MANAGEMENT, INC.	100.00%	11,656	(9,944)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,015	2,015	31
32	V	24	EDUCATION & SEMINAR	2,400	S.I.R. MANAGEMENT, INC.	100.00%		(2,400)	32
33	V	35	EQUIPMENT RENTAL	3,000	S.I.R. MANAGEMENT, INC.	100.00%		(3,000)	33
34	V	21	TELEPHONE & OFFICE	66,192	S.I.R. MANAGEMENT, INC.	100.00%		(66,192)	34
35	V	35	AUTO LEASE	4,200	S.I.R. MANAGEMENT, INC.	100.00%		(4,200)	35
36	V	25	TRAVEL	6,000	S.I.R. MANAGEMENT, INC.	100.00%		(6,000)	36
37	V	22	EMPLOYEE BENEFITS	6,600	S.I.R. MANAGEMENT, INC.	100.00%		(6,600)	37
38	V	6	REPAIRS AND MAINT.	5,400	S.I.R. MANAGEMENT, INC.	100.00%		(5,400)	38
39	Total			$ 1,043,023			$ 333,111	$ * (709,912)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 106,008	$ 106,008	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	106,008	CCS EMPLOYEE BENEFIT GROUP	100.00%		(106,008)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 106,008			$ 106,008	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 65	$ 65	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	43	43	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	94	94	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	81	81	18
19	V	32	INTEREST		ECM OWNERS COUNCIL	100.00%	61	61	19
20	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	1,126	1,126	20
21	V	17	MANAGEMENT FEES	15,600	ECM OWNERS COUNCIL	100.00%		(15,600)	21
22	V								22
23	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	17,961	17,961	23
24	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	1,045	1,045	24
25	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%	22	22	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,600			$ 20,498	$ * 4,898	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Dennis Tossi	Administrator	Administrative	3.12%	None	40	100.00%	Facility Sal	$ 126,916	17-1	1
2	Bryan Barrish	Stockholder	Administrative	14.63%	See Attached	9.68	19.36%	All. Sal/mgmt	86,557	17-7&3	2
3	Eric Rothner	Stockholder	Administrative	4.56%	See Attached	1.36	1.89%	All. Sal/mgmt	44,401	17-7&3	3
4	Mike Giannini	Stockholder	Administrative	7.31%	See Attached	8.61	17.22%	All. Sal/mgmt	81,736	17-7&3	4
5	Patricia McDiarmid	Stockholder	Administrative	0.48%	See Attached	10.76	21.52%	Alloc. Salary	15,493	17-7	5
6	Louise Bergthold	Stockholder	Administrative	0.72%	See Attached	11.84	21.53%	Alloc. Salary	36,590	17-7	6
7	Tom Winter	Stockholder	Administrative	0.72%	See Attached	9.94	16.57%	Alloc. Salary	23,562	17-7	7
8	Jeff Oravec	Stockholder	Administrative	0.48%	See Attached	8.61	21.53%	Alloc. Salary	15,046	17-7	8
9	Arturo Rominiquit	Relative	Clerical		See Attached	6.63	16.58%	Alloc. Salary	3,624	21-7	9
10	Nenita Guzman	Relative	Dietary		See Attached	11.84	21.53%	Alloc. Salary	11,216	1-7	10
11	Sarah Barrish	Relative	Clerical		None	2.36	Part Time	Salary	1,128	21-1	11
12											12
13								TOTAL	$ 446,269		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	878,492	11	$ 6,088	$	145,600	$ 1,009	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	878,492	11	8,220		145,600	1,362	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	878,492	11	5,069		145,600	840	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	878,492	11	142,165	142,165	145,600	23,562	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	878,492	11	18,910		145,600	3,134	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	878,492	11	3,657		145,600	606	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	878,492	11	472,061	403,426	145,600	78,239	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	878,492	11	1,858		145,600	308	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	878,492	11	6,465		145,600	1,072	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	878,492	11	4,146		145,600	687	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	878,492	11	74,163		145,600	12,292	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	878,492	11	30,298		145,600	5,022	12
13	32	INTEREST	BOOK./ACCNT.INCOME	878,492	11	11,823		145,600	1,960	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	878,492	11	15,297		145,600	2,535	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	878,492	11	26,147		145,600	4,334	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						10,008	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 826,367	$ 545,591		$ 146,970	25

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	642,911	10	$ 13,508	$	138,351	$ 2,907	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	642,911	10	63,644	42,834	138,351	13,696	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	642,911	10	7,250		138,351	1,560	3
4	10	NURSING	PATIENT DAYS	642,911	10	180,529	180,529	138,351	38,849	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	642,911	10	30,553		138,351	6,575	5
6	17	ADMINISTRATIVE	PATIENT DAYS	642,911	10	71,994	71,994	138,351	15,493	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	642,911	10	22,153		138,351	4,767	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	642,911	10	10,256		138,351	2,207	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	642,911	10	244,124	177,193	138,351	52,534	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	642,911	10	5,556		138,351	1,196	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	642,911	10	24,821		138,351	5,341	11
12	26	INSURANCE	PATIENT DAYS	642,911	10	5,468		138,351	1,177	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	642,911	10	45,778		138,351	9,851	13
14	30	DEPRECIATION	PATIENT DAYS	642,911	10	51,045		138,351	10,985	14
15	32	INTEREST	PATIENT DAYS	642,911	10	30,234		138,351	6,506	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	642,911	10	28,948		138,351	6,229	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	642,911	10	61,803		138,351	13,300	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 897,664	$ 472,550		$ 193,173	25

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	642,911	10	$ 52,122	$ 52,122	138,351	$ 11,216	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	642,911	10	8,770		138,351	1,887	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	642,911	10	831,558	831,558	138,351	178,947	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	642,911	10	113,620		138,351	24,450	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	642,911	10	$ 114,558	$	138,351	$ 24,652	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	56,277	56,277	37,032	25,126	8
9	15	EMP. BEN.-HEALTH CARE & I	SPECIAL REHAB INC.	82,944	4	$ 9,470	$	37,032	$ 4,228	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	237,604	10	165,366	165,366	59,884	41,678	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	237,604	10	$ 28,790	$	59,884	$ 7,256	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	67,672	67,672	21,600	11,656	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	11,698		21,600	2,015	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,459,901	$ 1,172,995		$ 333,111	25

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 106,008	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 106,008	25

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 676-2026
Fax Number: (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 400	$	15,600	$ 65	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		15,600	43	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	579		15,600	94	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	496		15,600	81	4
5	32	INTEREST	ECMOC MGMNT FEE INC.	96,000	9	374		15,600	61	5
6	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,931		15,600	1,126	6
7										7
8										8
9	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	81,858	81,858	9	17,961	9
10	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,762		9	1,045	10
11	17	ADMIN. SALARY	DIRECT ALLOCATION						22	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 95,664	$ 81,858		$ 20,498	25

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Nomura		X	Mortgage	$103,874.00	11/20/95	$ 12,500,000	$ 11,746,372	12/01/20	8.8800	$ 1,068,354	1
2												2
3												3
4												4
5												5
	Working Capital											
6	CIB Bank		X	Line of Credit	none	2/20/99	1,200,000	100,000	2/20/01	8.2500	11,080	6
7	Horton Insurance Agency		X	Insurance	$279.17	1/4/00					3,133	7
8												8
9	TOTAL Facility Related				$104,153.17		$ 13,700,000	$ 11,846,372			$ 1,082,567	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(14,633)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (14,633)	14
15	TOTALS (line 9+line14)						$ 13,700,000	$ 11,846,372			$ 1,067,934	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (22,836)	1
2	Interest Income-Bldg	X									(324)	2
3	Allocation from Preferred Bkkp	X									1,960	3
4	Allocation from ECM	X									61	4
5	Allocation from SIR Mgmt	X									6,506	5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (14,633)	21

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	450,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	457,960	2
3. Under or (over) accrual (line 2 minus line 1).	$	7,960	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	463,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	471,460	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	437,636	8
	1996	440,157	9
	1997	447,385	10
	1998	439,710	11
	1999	449,196	12

2000 accrual = 1999 actual tax x 3.18%
449,196 x 1.0318 = 463,480 (rounded)
Allocations: from Preferred Bookkeeping: $2,535; from SIR Mgmt: $6,229

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 211,753 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 7

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1		24,573	1991	$ 84,558	1
2					2
3	TOTALS	24,573		$ 84,558	3

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	417		1991	1991	$ 7,267,981	$ 230,730	35	$ 207,657	$ (23,073)	$ 2,863,931	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	61,428	601	20	3,071	2,470	23,424	9
10	Various			1994	120,534	1,729	20	6,026	4,297	38,355	10
11	Various			1995	291,499	8,103	20	14,331	6,228	78,293	11
12	PHONE SYSTEM			1996	3,386	302	20	169	(133)	845	12
13	PAINTING & DECORATIN			1996	2,084		20	104	104	451	13
14	REPLACE COMPRESSOR			1996	3,470	400	20	174	(226)	797	14
15	ELEVATOR WORK			1996	5,575	643	20	279	(364)	1,139	15
16	REBRICK BOILER			1996	7,070	181	20	354	173	1,505	16
17	COMPRESSOR			1996			20				17
18	ASBESTOS REMOVAL			1996	8,361	214	20	418	204	1,951	18
19	SEWER WORK			1996	7,700	197	20	385	188	1,797	19
20	PAINTING & DECORATIN			1996	2,322		20	116	116	483	20
21	REPIPE DINING ROOM			1996	6,426	165	20	321	156	1,578	21
22	NEW CONCRETE DRAIN			1996	12,272	850	20	614	(236)	2,712	22
23	BATHROOM RENOVATIONS			1997	12,195	313	20	610	297	1,932	23
24											24
25	PAGE 12-1 REP TOTALS				217,488	10,041		10,663	622	66,225	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33	PAGE 12C TOTALS				26,298	1,278		414	(864)	414	33
34	PAGE 12B TOTALS				460,548	17,469		15,009	(2,460)	17,928	34
35	PAGE 12A TOTALS				252,758	12,026		12,639	613	35,414	35
36	TOTAL (lines 4 thru 35)				$ 8,769,395	$ 285,242		$ 273,354	$ (11,888)	$ 3,139,174	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	KITCHEN DRAIN LINE			1997	3,200	82	20	160	78	573	9
10	HOT WATER TANK			1997	702	77	20	35	(42)	245	10
11	FLOORING			1997	6,235	160	20	312	152	1,092	11
12	BATHROOM RENOVATIONS			1997	10,217	262	20	511	249	1,661	12
13	BATHROOM RENOVATIONS			1997	10,702	274	20	535	261	1,694	13
14	KITCHEN TILE			1997	5,354	137	20	268	131	916	14
15	BATHROOM RENOVATIONS			1997	11,016	282	20	551	269	1,699	15
16	BOILER			1997	1,640	224	20	82	(142)	437	16
17	BATHROOM RENOVATIONS			1997	11,184	287	20	559	272	1,817	17
18	BATHROOM WORK			1998	1,830	47	20	92	45	238	18
19	BATHROOM RENOVATION			1998	6,941	178	20	347	169	1,041	19
20	WATER TANK			1998	3,883	746	20	194	(552)	517	20
21	CARPETING			1998	1,195		20	60	60	160	21
22	COMPRESSOR			1998	2,934	563	20	147	(416)	380	22
23	BLINDS			1998	4,247		20	212	212	548	23
24	ELECTRICAL WORK			1998	5,169	133	20	258	125	667	24
25	FIRE DAMPERS			1998	8,633	221	20	432	211	1,044	25
26	GENERATOR			1998	25,000	641	20	1,250	609	3,333	26
27	ADD'L FIRE DAMPERS			1998	1,957	50	20	98	48	204	27
28	PASSENGER ELEVATOR			1998	2,900	74	20	145	71	375	28
29	FIRE DOORS (7)			1998	8,976	1,724	20	449	(1,275)	1,310	29
30	METROM CONSTR.			1998	101,229	2,596	20	5,061	2,465	13,918	30
31	BOILER WORK			1998	2,322		20	116	116	261	31
32	FLOORING			1999	3,880		20	194	194	210	32
33	HOT WATER TANK			1999	5,150	1,648	20	258	(1,390)	495	33
34	ELEVATOR WORK			1999	5,062	1,620	20	253	(1,367)	464	34
35	PAINTING			1999	1,200		20	60	60	115	35
36	TOTAL (lines 4 thru 35)				$ 252,758	$ 12,026		$ 12,639	$ 613	$ 35,414	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	STAIRWAY			1999	600		20	30	30	38	9
10	CARPETING			1999	16,541	5,293	20	827	(4,466)	1,654	10
11	PAINTING &DECORATING			1999	818		20	41	41	68	11
12	SIR REMODELING			1999	23,330	598	20	1,167	569	1,459	12
13	PHONE EQUIP			1999	3,171		20	159	159	278	13
14	PIPING			1999	2,150		20	108	108	189	14
15	NEW PEDESTRIAN DOOR			1999	1,875		20	94	94	110	15
16	PHONE EQUIP			1999	471		20	24	24	40	16
17	FIRE ALARM SYSTEM			1999	173,676	4,453	20	8,684	4,231	9,408	17
18	HOT WATER FLOW			1999	6,485	2,075	20	324	(1,751)	432	18
19	BLINDS			1999	723		20	36	36	72	19
20	DOOR			1999	1,588		20	79	79	132	20
21	SEWER PIPING			1999	1,400		20	70	70	134	21
22	ELEVATOR WORK			1999	5,062		20	253	253	464	22
23	FIRE GRILLS &DAMPERS			1999	2,204		20	110	110	220	23
24	BASIN			1999	2,800		20	140	140	280	24
25	ELECTRICAL WIRING			1999	2,063		20	103	103	172	25
26	NEW FRNT DOORS			1999	2,185		20	109	109	127	26
27	LIGHT FIXTURES			2000	7,404	370	20	62	(308)	62	27
28	KITCHEN COMPRESSOR			2000	2,307		20	58	58	58	28
29	CEILING TILE			2000	3,111		20	26	26	26	29
30	NURSE CALL SYSTEM			2000	5,611	1,964	20	281	(1,683)	281	30
31	ELEVATOR WORK			2000	3,750	1,313	20	188	(1,125)	188	31
32	HVAC WORK			2000	4,344	652	20	90	(562)	90	32
33	ROOFING			2000	129,494	692	20	1,619	927	1,619	33
34	FLOORING			2000	2,110		20	97	97	97	34
35	DINING ROOM FLOOR			2000	55,275	59	20	230	171	230	35
36	TOTAL (lines 4 thru 35)				$ 460,548	$ 17,469		$ 15,009	$ (2,460)	$ 17,928	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	THERMOSTAT			2000	1,585		20	73	73	73	9
10	ELEVATOR WORK			2000	3,650	1,278	20	183	(1,095)	183	10
11	DOOR TROLLEY			2000	850		20	7	7	7	11
12	PAINTING			2000	16,595		20	69	69	69	12
13	PUMP/TANK ASSBLY			2000	1,398		20	12	12	12	13
14	Door ALARM			2000	1,098		20	37	37	37	14
15	OVERLOADS/COMPRESSOR			2000	1,122		20	33	33	33	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 26,298	$ 1,278		$ 414	$ (864)	$ 414	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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23											23
24											24
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993	SIR P/Pref	$ 23,403	$ 743	35	$ 669	$ (74)	$ 5,015	4
5			1993	SIR P/Sir M	57,502	1,826	35	1,643	(183)	12,322	5
6											6
7											7
8											8
	Improvement Type**										
9	ALBANY LTD PTRSHIP-LAND IMPROVEMENT			1993	58,478	3,453	20	4,500	1,047	30,930	9
10	Allocated from Preferred Bookkeeping			1997	29,227	1,102	20	1,461	359	5,566	10
11	Allocated from Preferred Bookkeeping			1999	232	74	20	12	(62)	17	11
12	Allocated from Preferred Bookkeeping			2000	1,466		20	30	30	30	12
13	Allocated from SIR Properties - Preferred Bkkpg			1999	2,965	297	20	148	(149)	222	13
14	Allocated from SIR Properties - Preferred Bkkpg			1998	1,417	142	20	71	(71)	177	14
15	Allocated from SIR Properties - Preferred Bkkpg			1997	88	9	20	4	(5)	20	15
16	Allocated from SIR Properties - Preferred Bkkpg			1994	223	6	20	11	5	72	16
17	Allocated from SIR Properties - Preferred Bkkpg			1993	380	20	20	19	(1)	142	17
18	Allocated from SIR Mgmt			1993	24,697	820	20	1,246	426	9,734	18
19	Allocated from SIR Mgmt			1994	77		20	8	8	49	19
20	Allocated from SIR Mgmt			1995	564	32	20	28	(4)	153	20
21	Allocated from SIR Mgmt			1999	2,683	178	20	134	(44)	162	21
22	Allocated from SIR Mgmt			2000	1,620	176	20	56	(120)	56	22
23	Allocated from SIR Properties - SIR Mgmt			1999	7,286	729	20	364	(365)	546	23
24	Allocated from SIR Properties - SIR Mgmt			1998	3,482	348	20	174	(174)	435	24
25	Allocated from SIR Properties - SIR Mgmt			1997	217	22	20	11	(11)	49	25
26	Allocated from SIR Properties - SIR Mgmt			1994	548	14	20	27	13	178	26
27	Allocated from SIR Properties - SIR Mgmt			1993	933	50	20	47	(3)	350	27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 217,488	$ 10,041		$ 10,663	$ 622	$ 66,225	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 467,104	$ 32,835	$ 46,467	$ 13,632		$ 291,666	37
38	Current Year Purchases	47,461	4,260	1,369	(2,891)		1,369	38
39	Fully Depreciated Assets	624,611	1,166		(1,166)		624,611	39
40								40
41	TOTALS	$ 1,139,176	$ 38,261	$ 47,836	$ 9,575		$ 917,646	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 9,993,129	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 323,503	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 321,190	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (2,313)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,056,820	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

ALBANY CARE, INC.
0037762
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
ALBANY CARE, INC.	351,633	24,058	35,164	11,106	218,687
Preferred Bookkeeping	33,952	2,432	3,151	719	20,824
SIR Properties - Preferred Bookkeeping	22		2	2	16
SIR Mgmt	81,443	6,344	8,145	1,801	52,099
SIR Properties - SIR Mgmt	54	1	5	4	40
TOTALS	467,104	32,835	46,467	13,632	291,666
LINE 29: CURRENT YEAR					
ALBANY CARE, INC.	43,917	3,616	1,162	(2,454)	1,162
Preferred Bookkeeping	989	198	83	(115)	83
SIR Properties - Preferred Bookkeeping					
SIR Mgmt	2,555	446	124	(322)	124
SIR Properties - SIR Mgmt					
TOTALS	47,461	4,260	1,369	(2,891)	1,369
LINE 30: FULLY DEPRECIATED					
ALBANY CARE, INC.	624,611	1,166		(1,166)	624,611
Preferred Bookkeeping					
SIR Properties - Preferred Bookkeeping					
SIR Mgmt					
SIR Properties - SIR Mgmt					
TOTALS	624,611	1,166		(1,166)	624,611
TOTALS (Should Tie to Totals on Page 13)					
ALBANY CARE, INC.	1,020,161	28,840	36,326	7,486	844,460
Preferred Bookkeeping	34,941	2,630	3,234	604	20,907
SIR Properties - Preferred Bookkeeping	22		2	2	16
SIR Mgmt	83,998	6,790	8,269	1,479	52,223
SIR Properties - SIR Mgmt	54	1	5	4	40
TOTALS	1,139,176	38,261	47,836	9,575	917,646

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: [ ] YES [X] NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 8,895 Description: see attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	see attached		$ #######	$ 29,129	17
18					18
19					19
20					20
21	TOTAL		$ #######	$ 29,129	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	n/a	hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **ALBANY CARE, INC.** **# 0037762** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	
5		
6		
7		
8		
9		
10		

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

STATE OF ILLINOIS

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 53,711	$ 62,893	1
2	Cash-Patient Deposits	38,857	38,857	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,600,877	1,600,877	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,801	7,801	6
7	Other Prepaid Expenses	3,104	3,104	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	166,997	166,997	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,871,347	$ 1,880,529	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		84,558	13
14	Buildings, at Historical Cost		7,267,981	14
15	Leasehold Improvements, at Historical Cost	998,734	1,057,212	15
16	Equipment, at Historical Cost	1,232,512	1,232,512	16
17	Accumulated Depreciation (book methods)	(1,204,817)	(3,342,808)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	137,375	137,375	22
23	Other(specify): See supplemental schedule		153,286	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,163,804	$ 6,590,116	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,035,151	$ 8,470,645	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 120,341	$ 120,341	26
27	Officer's Accounts Payable	62,052	62,052	27
28	Accounts Payable-Patient Deposits	42,561	42,561	28
29	Short-Term Notes Payable	100,000	100,000	29
30	Accrued Salaries Payable	298,208	298,208	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,704	15,704	31
32	Accrued Real Estate Taxes(Sch.IX-B)	463,500	463,500	32
33	Accrued Interest Payable	230	61,076	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	51,000	51,000	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,153,596	$ 1,214,442	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,746,372	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule		17,375	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 11,763,747	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,153,596	$ 12,978,189	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,881,555	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,035,151	$ #REF!	48

*(See instructions.)

Facility Name & ID Number ALBANY CARE, INC. **#** 0037762 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	166,568	166,568
Employee Advances	429	429
	166,997	166,997

OTHER CURRENT LIABILITIES:	Amount	Amount

OTHER NON CURRENT ASSETS:		
Capital Reserves		17,375
Loan Fees - Net		135,911
		153,286

OTHER NON CURRENT LIABILITIES:		
Credit Reserves		17,375
		17,375

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,886,381	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,886,381	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,538,874	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(2,543,700)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (4,826)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,881,555	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	ALBANY CARE, INC.	#	0037762	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		1,886,381
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		1,886,381
Equity(Deficit) from Page 17 Col 1		1,881,555
Related Party		
Equity(Deficit)	-6805522	
Income	416423	
		(6,389,099)
Combined Equity - End of Year		(4,507,544)

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,170,311	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,170,311	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	22,836	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 22,836	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	5,653	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,653	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,198,800	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,562,785	31
32	Health Care	3,001,098	32
33	General Administration	2,546,470	33
	B. Capital Expense		
34	Ownership	2,320,639	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	228,934	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,659,926	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,538,874	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,538,874	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **ALBANY CARE, INC.** **# 0037762** **Report Period Beginning:** **01/01/00** **Ending:** **12/31/00**

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	Jury Duty - CNA : adjusted out on page 5	190
3	Rental of facility space : adjusted out on page 5	5,463
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	5,653

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,810	2,091	$ 91,233	$ 43.63	1
2	Assistant Director of Nursing	3,961	4,414	89,244	20.22	2
3	Registered Nurses	2,835	2,972	63,989	21.53	3
4	Licensed Practical Nurses	37,798	40,924	678,528	16.58	4
5	Nurse Aides & Orderlies	95,078	99,909	782,227	7.83	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,261	3,570	50,214	14.07	9
10	Activity Assistants	48,863	52,145	352,306	6.76	10
11	Social Service Workers	30,388	33,003	409,412	12.41	11
12	Dietician					12
13	Food Service Supervisor	1,873	2,091	36,301	17.36	13
14	Head Cook	4,715	5,211	40,488	7.77	14
15	Cook Helpers/Assistants	21,667	22,893	159,319	6.96	15
16	Dishwashers					16
17	Maintenance Workers	4,665	4,897	53,518	10.93	17
18	Housekeepers	27,629	29,899	209,968	7.02	18
19	Laundry					19
20	Administrator	1,834	2,203	126,917	57.61	20
21	Assistant Administrator	2,299	2,618	49,953	19.08	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	24,955	27,334	260,420	9.53	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,598	8,420	117,339	13.94	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	321,229	344,594	$ 3,571,376 *	$ 10.36	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	allocation	$ 21,600	1-3	35
36	Medical Director	monthly	3,000	9-3	36
37	Medical Records Consultant	96	4,032	10-3	37
38	Nurse Consultant	allocation	82,572	10-3	38
39	Pharmacist Consultant	monthly	1,800	10-3	39
40	Physical Therapy Consultant	16	775	10A-3	40
41	Occupational Therapy Consultant	77	3,850	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Specialized Rehab	monthly	37,032	10A-3	46
47	Director of Food Services	allocation	42,540	1-3	47
48					48
49	TOTAL (lines 35 - 48)	189	$ 197,201		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	328	$ 7,210	10-3	50
51	Licensed Practical Nurses	11,117	179,545	10-3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	11,445	$ 186,755		53

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Dennis Tossi	Administrator	3.12%	$ 126,916
Anthony Madl (1/00-12/00)	Asst. Admin	0%	40,956
Philip Rosenberg (1/00-3/00)	Asst. Admin	0%	8,997
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 176,869

B. Administrative - Other

Description	Amount
Management Service Fees - See Attached	$ 52,548
Management Fees - See Attached	803,775
Directors Fees - See Attached	90,125
TOTAL (agree to Schedule V, line 17, col. 3)	$ 946,448
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Preferred Bookkeeping	Accounting	$ 20,500
Frost, Ruttenberg & Rothblatt	Accounting	11,460
Preferred Bookkeeping	Computer Services	10,008
SIR Management	Director of Regulatory Serv	33,780
Personnel Planners	Unemployment Consultant	1,283
Triad Computer Support	MDS Support	1,320
Integrated Communication	Website	1,555
Schwartz & Freeman	Legal	47,387
Stuart Sikes	Collection Fees (adj out p5)	250
Stone, McGuire & Benjamin	Legal	11,038
Preferred Bookkeeping	Bookkeeping Fees	125,100
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 263,681

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,098
Unemployment Compensation Insurance	16,423
FICA Taxes	273,190
Employee Health Insurance	70,380
Employee Meals	13,908
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits	16,134
Union Health & Welfare	75,973
TOTAL (agree to Schedule V, line 22, col.8)	$ 496,106

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	13,643
Health Care Worker Background Check	460
(Indicate # of checks performed 33)	
Licenses & Fees	24,590
Dues & Subscriptions	14,038
Allocation from Preferred Bookkeeping	606
Allocation from ECM	43
Allocation from SIR Mgmt	2,207
Advertising & Promotion	3,038
Less: Public Relations Expense	( )
Non-allowable advertising	(3,038)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 55,787

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,621
Allocation - SIR Mgmt	1,196
Allocation - Preferred Bookkeeping	308
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,125

**See instructions.

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	1994	$ 2,074	3	$ 346	$	$	$	$	$	$	$	$
2	Painting & Decorating	1995	172,920	3	57,640	4,589							
3	Painting & Decorating	1997	11,558	3	1,926	3,853	3,853	1,926					
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 186,552		$ 59,912	$ 8,442	$ 3,853	$ 1,926	$	$	$	$	$

Facility Name & ID Number ALBANY CARE, INC. # 0037762 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? yes

(2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. Il Council L-T care: 11,288

(3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 180 Line 1

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 228,933
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 13,908 Has any meal income been offset against related costs? no Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100% of line
d. Have vehicle usage logs been maintained? yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? no
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? yes
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? no
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.